A Pattern of Pathologizing: Creativity, Intelligence, and PTSD Responses Reframed as Mental Illness

I.P.K. (formerly known by another name)
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A case study in coercive control, pathologizing, and institutional systems abuse.

Thesis

He consistently chose the perspective that could paint her in the worst possible light when she was most vulnerable. This was consistent in the patterns.

This document establishes a documented pattern across at least thirteen years in which the reporting party, S.K., presented two categories of behavior to institutional authorities — medical providers and law enforcement — in ways that systematically misrepresented their nature:

- Creative excitement, intelligence, and artistic momentum were characterized as psychiatric symptoms (flight of ideas, pressure of speech, mania).
- PTSD reactions, trauma responses, and flashbacks were characterized as dangerous delusion, psychosis, and non-compliance.

This pattern is consistent with the coercive control framework established by Evan Stark in Coercive Control: How Men Entrap Women in Personal Life (2007), specifically the tactic of pathologizing — using medical and institutional systems to redefine a partner's normal behavior, emotional responses, and capacities as evidence of mental illness, in order to undermine her credibility, autonomy, and access to support.

Instance One: Approximately 2006

Who Dr. R. Was — and How She Came to Be His Patient

Dr. R. was S.K.'s doctor. He became her doctor because S.K. persistently pressured her to leave the community clinics she had been using and insisted she needed "a better doctor." He arranged for her to be seen by his own physician. She did not independently choose this provider.

This same doctor — Dr. R. — later failed to identify a brain aneurysm. He had ordered an MRI, which is not the optimal diagnostic tool for aneurysm detection. She had to conduct her own research, draw her own clinical conclusions, and advocate specifically for an MRA — the correct diagnostic tool — before it was identified. Without her own self-advocacy, the aneurysm may not have been caught.

The referral that produced the 2006 psychiatric consultation therefore came from a doctor who was S.K.'s doctor first, placed in her life through S.K.'s pressure, and who had already demonstrated a significant diagnostic failure that she herself had to correct. Her medical care, like her legal representation years later, was routed through his network — leaving her with providers who had no independent relationship with her and whose initial point of contact was the person who controlled her access to care.

The Nature of the Appointment — What the Document Actually Shows

The clinical record describes a semi-urgent referral from Dr. R. The presenting situation was as follows:

- She had been reducing Seroquel on her own from 150mg to 25mg, believing it was causing shoulder twitches
- A workplace trigger occurred — a client gave her a website that triggered a flashback: "a flashback to when I was programmed which may or may not have been real" — she became terrified
- In response to that terror, she increased her Seroquel herself to 400mg — appropriate self-management — and was feeling calmer by the time of the appointment
- **She came in specifically to ask: what do I do about my medication going forward?**

This is not a person who refuses medication. This is a person who was actively monitoring her own symptoms, self-adjusting her medication in response to a trauma trigger, stabilizing herself, and then seeking professional guidance on next steps. She initiated the medication conversation. She was the one asking the questions.

Separately, S.K. reported to the psychiatrist that a couple of days before the trigger episode, she had been speaking rapidly about her choreography — which he characterized as flight of ideas and pressure of speech. This observation was unconnected to the trigger event. It was her excitement about her artistic work, reported by him as a psychiatric symptom.

The family history recorded in this document — schizophrenic siblings, hospitalized father — came entirely from S.K., not from her.

A Direct Contradiction: 2006 Record vs. 2019 Police Report

In 2019, S.K. told the responding deputy:

> ***"She suffers from Bipolar disorder but refuses the diagnosis and will not take medication."***

The 2006 clinical record — an appointment he attended, in a room he sat in — documents the direct opposite. She was the one asking about her medications. She was the one who had self-adjusted her dose in response to a trauma trigger. She was the one who came in for professional guidance on how to manage them correctly.

He was present. He knew this. Thirteen years later, he told a deputy the opposite.

She Was Not Making It Up

At her workplace — a law office — she had come face to face, on more than one occasion, with a man connected to a church where she and her sisters had been assaulted as adolescents. The assaults had occurred in a hotel room adjacent to where the church met. The church service in one room, the assault room in another. She was shocked the first time he came into the reception area to ask how she was. There was no need for him to be there. She told him she was fine and kept working. The work he did was on the second floor, and there was no reason for him to pass by her desk. The IT manager, when she asked about why he kept coming back, said he couldn't figure it out — the ducts never seemed to get fixed and he kept coming back.

She was coping — with a self-designed playlist of EMDR and other therapeutic techniques she could access discreetly at her desk. She used clonazepam only in emergencies. When she was severely triggered at work, she called S.K. He would listen. He would help her calm down. He was her primary co-regulator for these episodes.

S.K. knew the source of her distress was real and external — not internal pathology. He had heard her fear directly, in real time, from the workplace. He knew she was not imagining it. A therapist who understood her trafficking history had already correctly identified the dynamic and advised her to leave the job — explaining that workplaces sometimes intentionally trigger survivors, because a survivor healing and thriving sends a signal to others that escape and recovery are possible. S.K. disagreed with this advice. She stayed — because she needed the income to pay him rent to remain in the shared residence, to fund the dance company, and to maintain health insurance.

What He Said — to the Psychiatrist

With full knowledge of all of the above, S.K. reported to the consulting psychiatrist that she had demonstrated "flight of ideas and pressure of speech." His evidence: she had been speaking rapidly and with excitement about her dancing and choreography. In her own words, documented in the clinical record:

> ***"I was so excited about some new things with my dancing and choreography."***

He did not tell the psychiatrist about the workplace situation. He did not tell the psychiatrist that she had come face to face with a former abuser. He did not tell the psychiatrist that she had been calling him from the office in distress, and that he had been co-regulating her through genuine trauma responses. He did not tell the psychiatrist what her trafficking-aware therapist had identified and recommended.

He reported her creative excitement as a psychiatric symptom. The physician recorded it as flight of ideas and pressure of speech — consistent with a bipolar presentation. This characterization entered the psychiatric record and reinforced a misdiagnosis that, per her current treating psychiatrist, harmed her body and slowed her healing by approximately a decade.

What Was Actually Happening in 2006

In 2006, I.P.K. was the Artistic Director of a contemporary dance company she had built through eight prior failed attempts. 2006 represented the company's first major breakthrough: its first tour outside her home city. The following is drawn directly from her professional record:

- World premiere of an original quintet — presented at a regional dance alliance new works concert
- First tour outside home city — Monterey Dance Festival
- Original site-specific work — Choreographer, Photographer, Performer
- Community service concert — Presenter/Producer (Music Academy of the West)
- Humanitarian award concert — Presenter/Producer
- Master class series — Presenter/Producer
- Administrative support for two of S.K.'s music concerts during the same period

She was simultaneously providing administrative support for multiple projects centered on S.K.'s musical career. She had achieved her first major professional milestone after years of sustained effort. Her excitement was commensurate with her accomplishment.

Analysis

A person with PTSD and Dissociative Identity Disorder who speaks rapidly and with excitement about a creative breakthrough is not exhibiting a psychiatric symptom. She is exhibiting the normal emotional response of an artist whose years of work are finally producing results.

S.K. was present for all of it. He was with her when she finished her B.A. with highest honors. He was with her as she completed her MFA. He was with her when she launched a non-profit and a dance company, and had 8 failures before the company finally took, all while also producing his musical events. She also served as the volunteer executive director of the non-profit. He knew what was happening in 2006. She was excited and full of ideas because she had discovered how to get her work out of town, and the company had its first tour. She knew of her dream to grow the company to international status. Once she had it up and running, he would ask if he could join the company. He chose to present her aliveness as pathology.

Instance Two: October 12, 2019

What He Said — to the Responding Deputy

From the police report, case no. [redacted], October 2019:

> *"She suffers from Bipolar disorder but refuses the diagnosis and will not take medication. He stated there have been no prior incidents this violent but she does become manic and unpredictable at times."*
>
> *"She can overpower him and he believes she could seriously injure him."*

These statements traveled directly into every psychiatric intake document that followed, each time attributed to “per husband.”

What Was Actually Happening on October 12, 2019

I.P.K. was in acute medical delirium from an untreated urinary tract infection. This was documented in writing by the attending physician at the Psychiatric Health Facility, Dr. G., in a letter to the presiding judge dated October 22, 2019:

> ***“The urinary tract infection is the ultimate cause of her presentation; she was delirious which is a medical issue, not a psychiatric issue.”***

Dr. G. instructed I.P.K. to deliver a direct message to S.K. before her discharge:

> ***“Tell your husband: next time, your wife needs antibiotics, not antipsychotics. She has a history of urinary tract infections.”***

I.P.K. delivered this message. S.K. received it before her discharge. He was directly informed by the attending physician that the cause of her presentation was medical — not psychiatric. Any subsequent characterization of her presentation as psychiatric was made with full knowledge of Dr. G.’s clinical finding.

What the Record Also Shows

- No injuries were documented. S.K. declined medical examination. The police report states he was uninjured.
- The bipolar diagnosis he reported was not her current clinical diagnosis. Formally ruled out by her treating psychiatrist Dr. M. (2014–2018); not held by Dr. B. (2019–present).
- She was not medication non-compliant. She was on an active physician-directed protocol: Seroquel 25mg PRN plus medically supervised cannabis, referred by Dr. M.
- She is 4’11”, approximately 100 lbs. He is 6’1”, 160 lbs. The claim that she could overpower him is contradicted by the physical record.

The Context of October 2019: Chosen Vulnerability

He did not act when she was stable, grounded, and in the flow of her work. He turned up the fire when her system was already destabilized. October 2019 was not a random moment. It was a moment of compounding, layered vulnerability.

At the time of the arrest, she was carrying:

- The loss of a 14-year job — laid off when the law firm restructured and eliminated her position — a fact he presented as: she got fired because she couldn’t do the work anymore
- The recent death of her sister

- The recent death of her brother
- The death of the family cat
- Active, layered, compounding grief — for which she had been seeing a grief counselor for 27 sessions
- Enrollment in four graphic design classes at a local community college — actively rebuilding her career
- A New York project in preparation for the company she had arranged — professional momentum continuing despite personal loss
- Decades of gaslighting that had left her unable to trust her own read on her symptoms — knowing something wasn't right but unable to determine whether it was the grief, PTSD, or something else
- A body already under enormous stress — physically vulnerable, with a documented history of UTIs, in a period of prolonged grief and nervous system dysregulation

He Increased the Pressure at the Worst Possible Moment

During this period of compounding loss and destabilization, S.K. pressured her to go on a camping trip she did not want to take. She had communicated clearly that she did not want to go. He pressured her until she complied. The camping trip is the likely origin point of the UTI, with atypical behavior already emerging — such as demanding that a person with a chainsaw trimming a eucalyptus tree stop, which was triggering her fear — and which would become the medical emergency on October 12, 2019.

He then used the symptoms of that UTI — the confusion, the disorientation, the delirium — against her when she was incapacitated and could not speak for herself. He called 911. He described a psychotic bipolar woman. He provided intake clinicians with a distorted version of her history. He watched the institutions do the rest.

"Stop Breaking Me"

She told him, repeatedly, in her own words:

> ***"Stop breaking me. I don't need you to rescue me and fix me."***

She brought this to couples counseling. She named the dynamic explicitly. She told him: you work on your stuff, I'll work on mine.

The therapists consistently sided with his framing. Her observations were not validated. Her testimony about the dynamic was absorbed into a therapeutic framework that treated his perspective as the more reliable account. This is consistent with what the coercive control literature identifies as a common failure mode in couples therapy with controlling partners: the therapist, lacking awareness of coercive control dynamics, inadvertently reinforces the abuser's narrative by treating both partners as equally positioned to negotiate in good faith.

She was telling the truth. In couples counseling. In front of witnesses. Repeatedly. It was not heard — until a grief counselor told her to educate herself about narcissistic traits. She educated herself, and told S.K. what her counselor thought was going on. He

was aware that she was considering the possibility that he had an issue that was causing harm in the relationship.

The No-Win Architecture

The abuse continued. The triangulations continued. The gaslighting continued. The financial extraction continued. He never did the work he claimed he would do. She was left in a structure where:

- When she was stable and functioning, her stability was used to deny that anything was wrong
- When she was destabilized, her destabilization was used as evidence of her pathology
- When she named the dynamic, therapists sided with his framing
- When she sought institutional support, institutions received his account first and built their records around it

This is not a relationship that went wrong at a particular moment. This is a system that was built, over decades, to ensure there was no exit that did not cost her everything. October 2019 was not an anomaly. It was the system operating as designed — at the moment she was most unable to defend herself.

The Pattern: Thirteen Years, Same Mechanism

- 2006: Creative excitement and artistic momentum reported to psychiatrist as flight of ideas and pressure of speech — entered record as bipolar symptom.
- 2019: Acute medical delirium from untreated UTI reported to deputy as “manic and unpredictable” — entered arrest record and every subsequent psychiatric intake document.

In both cases: he was present. He had direct knowledge of the actual circumstances. He chose the framing that served the worst possible characterization of her — and he delivered it at the moment she was least able to respond.

The PTSD Dimension

When I.P.K. experienced PTSD reactions — hypervigilance, rapid speech, heightened affect, fear responses, dissociative states, nervous system flooding — S.K. reported these responses to institutional authorities as evidence of danger and psychiatric instability. He knew what the very first diagnosis she received was, and later, when a misdiagnosis entered the journey, he used this as a weapon to serve his own needs and objectives.

He was both the source of the trigger and the person reporting the triggered response as pathology. He created the conditions that activated her nervous

system, then used her activated nervous system as evidence against her. This is the closed loop of coercive control.

Framework: Evan Stark's Coercive Control

Evan Stark's Coercive Control: How Men Entrap Women in Personal Life (2007) — the foundational academic work on which California Family Code § 6320(c) is based — identifies pathologizing as a core coercive control tactic. Pathologizing involves redefining a partner's normal behavior, emotional responses, and capacities as symptoms of mental illness, in order to:

- Undermine her credibility with institutions (medical, legal, community)
- Isolate her from support networks by characterizing her as unstable or dangerous
- Use those institutions as instruments of control (systems abuse)
- Create a documented record that serves the abuser's narrative while erasing the victim's

California Family Code § 6320(c) (amended by S.B. 1141, effective January 1, 2021) codifies coercive control as a pattern of behavior that "in purpose or effect unreasonably interferes with a person's free will and personal liberty," including conduct committed "directly or indirectly, including through the use of a third party" — meaning the use of psychiatric institutions and law enforcement as vehicles for false or misleading characterizations qualifies.

The documented pattern in this case — presenting creative excitement as mania, presenting medical delirium as psychosis, presenting PTSD reactions as dangerous instability, across multiple institutions over at least thirteen years — is a textbook example of pathologizing as coercive control.

The Daily Mechanism: Gaslighting as the Architecture of Control

The documented contradictions in this record are not isolated errors or misrememberings. They are the institutional expression of a dynamic that operated daily, privately, over three decades.

She knew her own reality. He told her — consistently, persistently — that her reality was incorrect and his was accurate. She pushed back. She corrected him. She kept records. She brought it to couples counseling. None of it was sufficient, because the institutions that might have validated her account received his version first, delivered with confidence, while she was either absent, incapacitated, or present but unable to be heard.

The specific contradictions documented in this record illustrate the pattern:

- She knew she was medication compliant — she was the one managing her own doses, calling the doctor, asking the questions. He told the deputy she refused medication.
- She knew when the relationship began — she has six independent archived sources. He told the officer a different date.
- He eventually knew the UTI was the cause of her presentation — the attending physician told him directly, through her. He let the psychiatric framing stand.
- He knew her excitement was about her choreography — her first tour, her breakthrough, eight attempts finally succeeding. He reported it to the psychiatrist as a symptom.
- He knew they were not legally married — he had declared their ceremony moot and refused to register it. When she was completely incapacitated, he upgraded his status to “husband” in communications to the Psychiatric Health Facility. He had previously been informed by a physician that having the same last name would allow him access in a medical emergency without legal marriage. He used this, in her assessment, to present himself as her husband.

Each time: her reality, clearly known to her, replaced by his version — delivered to institutions with authority and confidence.

Evan Stark, in Coercive Control (2007), identifies this as among the most damaging dimensions of coercive control — what he terms liberty crimes: not just physical control, but the systematic theft of a person’s ability to trust her own mind, her own perceptions, her own account of her own life. The target is not the body. The target is reality itself.

She was not living in insanity. She was living with someone who was methodically constructing an alternative reality and presenting it everywhere that mattered — to doctors, to deputies, to psychiatric intake workers, to attorneys, to the arts community, to couples therapists who consistently sided with his framing.

She kept pushing back. She kept correcting him. She kept the records. This document is the result.

Closing Observation

The arc of her documented professional life — from the first fragmented DID paintings in the 1990s to the stitched, integrated portraits performed on stage in New York in 2018 and at home in 2019 — is not the arc of an unmedicated bipolar person who refused help.

It is the arc of a woman who did the work of healing, documented it publicly, and was celebrated for it.

Seven months after that final performance, he called 911 and told the deputy she was manic and unpredictable.

He chose the perspective that could paint her in the worst possible light when she was most vulnerable.

This was consistent in the patterns.

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